BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Mona P. Tahilramaney, M.D.	)	File No. 06-2005-166836
Physician's and Surgeon's Certificate No. A 38363	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on **August 8, 2008 .**

IT IS SO ORDERED **July 10, 2008 .**

MEDICAL BOARD OF CALIFORNIA

By: _____
Barbara Yaroslavsky, Chair
Panel B
Division of Medical Quality

EDMUND G. BROWN JR., Attorney General
of the State of California
COLLEEN M. McGURRIN, State Bar No. 147250
Deputy Attorney General
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 620-2511
Facsimile: (213) 897-9395

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MONA P. TAHILRAMANEY, M.D. 20911 Earl Street, Suite 460 Torrance, California 90503 Physician & Surgeon's Certificate No. A38363, Respondent.	Case No. 06-2005-166836 OAH No. L2007110342 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Barbara Johnston (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California, by Colleen M. McGurrin, Deputy Attorney General.

2. Respondent, Mona P. Tahilramaney, M.D. is represented in this proceeding by attorney Peter R. Osinoff, of Bonne, Bridges, Mueller, O'Keefe & Nichols, 3699 Wilshire Boulevard, 10th Floor, Los Angeles, California 90010-2719.

///

3. On or about April 19, 1982, the Board issued Physician and Surgeon's Certificate number A38363 to Mona P. Tahilramaney, M.D. That license was in full force and effect at all times relevant to the charges brought in Accusation number 06-2005-166836 and will expire on November 30, 2009, unless renewed.

JURISDICTION

4. Accusation Number 06-2005-166836 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on October 10, 2007. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation number 06-2005-166836 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation number 06-2005-166836. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

///

///

CULPABILITY

8. Respondent admits the truth of the charges and allegations in the First Cause for Discipline, paragraphs A, B, C and D (Repeated Negligent Acts) and admits the truth of each and every charge and allegations in the Third Cause for Discipline (Failure to Maintain Adequate and Accurate Medical Records) in Accusation Number 06-2005-166836. Respondent further understands and agrees that, at a hearing Complainant could establish a prima facie basis for the charges and allegations in the First Cause for Discipline, paragraphs E, F and G in the Accusation, and that Respondent hereby gives up her right to contest the charges and allegations specified in this paragraph.

9. Respondent agrees that, based upon the above admissions and agreements, her Physicians and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

10. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

11. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

12. In consideration of the foregoing admissions and stipulations, the parties

agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physicians and Surgeon's Certificate Number A38363 issued to Respondent Mona P. Tahilramaney, M.D. is revoked. The revocation, however, is stayed and Respondent is placed on probation for one (1) year on the following terms and conditions.

1. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision will be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision and Order.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after the effective date of the Decision.

2. CLINICAL TRAINING PROGRAM Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and

which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

If respondent fails to complete the clinical training program within the designated time period, respondent shall cease the practice of medicine within 72 hours after being notified by the Division or its designee that respondent failed to complete the clinical training program.

3. NOTIFICATION Prior to engaging in the practice of medicine, the respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or

insurance carrier.

4. SUPERVISION OF PHYSICIAN ASSISTANTS During probation, respondent is prohibited from supervising physician assistants.

5. OBEY ALL LAWS Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

6. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

7. PROBATION UNIT COMPLIANCE Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California Physicians and surgeon's license.

Respondent shall immediately inform the Division, or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

8. INTERVIEW WITH THE DIVISION, OR ITS DESIGNEE Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee, upon request at various intervals, and either with or without prior notice throughout the term of probation.

9. RESIDING OR PRACTICING OUT-OF-STATE In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Division

or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically canceled if respondent's periods of temporary or permanent residence or practice outside California total two years. However, respondent's license shall not be canceled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

10. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically canceled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

11. COMPLETION OF PROBATION Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

12. VIOLATION OF PROBATION Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. LICENSE SURRENDER Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the

application shall be treated as a petition for reinstatement of a revoked certificate.

14. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which are currently set at $3,173.00, but may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter R. Osinoff, Esq. I understand the stipulation and the effect it will have on my Physician and Surgeon's Certificate. I enter into this Stipulated Settlement and

Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 5/28/08

Mona P. Tahilramaney MD.

MONA P. TAHILRAMANEY, M.D.
Respondent

I have read and fully discussed with Respondent Mona P. Tahilramaney, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 5/29/08

PETER R. OSINOFF, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: June 2, 2008

EDMUND G. BROWN JR., Attorney General
of the State of California

COLLEEN M. McGURRIN
Deputy Attorney General

Attorneys for Complainant

50256265
LA2007502299

Exhibit A

Accusation No. 06-2005-166836

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Oct 10, 2007
BY Brenda Allen ANALYST

EDMUND G. BROWN JR., Attorney General
of the State of California
COLLEEN M. McGURRIN, State Bar No. 147250
Deputy Attorney General
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 620-2511
Facsimile: (213) 897-9395

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MONA P. TAHILRAMANEY, M.D. 20911 Earl Street, Suite 460 Torrance, California 90503 Physician and Surgeon's Certificate No. A38363, Respondent.	Case No. 06-2005-166836 OAH No. **ACCUSATION**

Complainant alleges:

PARTIES

1. Complainant, Barbara Johnston, brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California (Board.)

2. On or about April 19, 1982, the Board issued Physician and Surgeon's Certificate number A38363 to Mona P. Tahilramaney, M.D.[1] (Respondent). This license was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2009, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board's Division of Medical Quality

1. Mona P. Tahilramaney, M.D. is also known as Mona P. Ramaney or Dr. Ramaney.

(Division) under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the division.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division.

"(4) Be publicly reprimanded by the division.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the division and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical

Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

7. Respondent is subject to disciplinary action under section 2234, subdivision (c) in that she was negligent in her care and treatment of patient Susan O.[2] The circumstances are as follows:

8. On or about May 8, 2003, Susan O., then a 36-year-old married female,

---

2. For privacy, the patient in the Accusation will be identified by their first name and last initial. The full name will be disclosed to Respondent upon timely request for discovery pursuant to Government Code section 11507.6.

presented to Respondent with a history of mid-cycle bleeding for many months, although she had been having her regular monthly menstrual cycle. The patient informed Respondent that she had been trying to get pregnant, and was concerned that the mid-cycle bleeding might be causing problems in this regard. She also told Respondent that she was previously diagnosed with hypothyroidism and was taking Synthroid daily.

9. During the May 8, 2003, office visit, Respondent opined that the patient may have a uterine polyp. Respondent thereafter recommended a hysteroscopy and a dilation and curettage (D&C) to remove a suspected uterine polyp. Respondent discussed the risks and benefits of the planned surgical procedures, and Susan O. agreed to them. Respondent did not discuss any other treatment options or surgical procedures. Respondent did not suggest, order or perform any other diagnostic studies at that time, other than the pre-admission labs for a Complete Blood Count (CBC) and Urinanalysis (UA.)

10. The surgery was scheduled for 7:30 a.m. on June 2, 2003, at Little Company of Mary Hospital. Respondent did not schedule a preoperative office visit with the patient prior to the surgery, nor did Respondent speak with her in the interim.

11. Approximately one week before the scheduled surgery, Susan O. went to Little Company of Mary Hospital for her pre-admission visit. At that time, the patient gave a blood and urine sample, completed some paperwork, and the hospital staff spoke with her briefly about the procedures she was to have on June 2, 2003.

12. On June 2, 2003, Susan O. arrived at the hospital, around 6:00 a.m. The "Authorization for and Consent to Surgery or Special Diagnostic or Therapeutic Procedures," reflecting the patient's signature and consent for the hysteroscopy and D & C (suction) for endometrial polyp, showed no other surgical procedures at that time.

13. Shortly before the surgery, Respondent saw Susan O. and identified her as the patient she would be operating on that morning. Respondent did not, however: discuss or confirm, with the patient, what surgical procedures were to be performed that morning; review or discuss the consent form previously given to Susan O. for her signature; witness the patient sign any consent form for the surgical procedures to be performed that morning.

14. Before Susan O. was taken to the operating room, the same day nurse notified Respondent that there was a discrepancy between the consent form and the procedures listed on the operating room surgical schedule. The surgical schedule included an endometrial ablation procedure[3] that was absent from the consent form. Respondent took no action to investigate the discrepancy and did not ask to see the surgical schedule.

15. Thinking she made a mistake, Respondent requested the hospital staff to get consent for the endometrial ablation, which they did. Respondent, however, did not discuss the endometrial ablation procedure with Susan O., and did not know what, if anything, the patient was told in order to obtain her consent for the procedure.

16. In surgery, Respondent proceeded with the hysteroscopy and did not see any polyps, although she noted some irregularities of the uterine wall which looked like polyploid structures. Respondent then proceeded with the D&C, and noted a little more fresh blood coming out than usual. Respondent reinserted the hysteroscope, and noted a little continuous bleeding coming down the side where the D&C had been performed. Respondent decided that, since the patient had consented to an endometrial ablation and was scheduled for it, she would utilize the ThermaChoice[4] ablation device to cauterize the bleeding.

17. During the endometrial ablation, Respondent noticed that the pressure of the ThermaChoice device kept dropping.[5] After approximately 3 to 4 minutes, Respondent stopped the procedure as the pressure was low. Respondent then reinserted the hysteroscope and saw that the bleeding had stopped.

---

3. Endometrial ablation is a medical procedure that is used to remove (ablate) or destroy the endometrial lining of a woman's uterus. Uterine ablation is contraindicated in patients who may want to get pregnant as it removes the endometrial lining necessary for implantation of a fertilized egg and the ability to carry a baby to term.

4. ThermaChoice, manufactured by Gynecare, is the brand name of the ablation device utilized in this surgery. There are several other manufacturers and brand names.

5. Gynecare's "ThermaChoice III" literature states that possible uterine perforation is indicated, among other things, if the pressure cannot be stabilized, or if the pressure drops quickly at any point.

18. Respondent next saw Susan O. on or about June 23, 2003, for a post-operative office visit. They discussed the patient's desire to get pregnant shortly after the surgery. Respondent told the patient her regular menstrual cycle should resume within six weeks. According to Susan O., Respondent did not inform her about the endometrial ablation, and there is no documentation that she was so informed. Respondent did not inform her that it was very important to use some form of birth control or contraception consistently and correctly as pregnancies following endometrial ablations can be dangerous and potentially life-threatening for the fetus and/or mother. Additionally, Respondent did not inform the patient that there was a low likelihood that Susan O. would be able to carry a pregnancy following the ablation due to the destruction of the endometrial lining.

19. On or about August 19, 2003, Respondent spoke with Susan O. over the phone. The patient still had not resumed her monthly menstrual cycle, although she reported one day of spotting in July and one day of spotting in August. Respondent prescribed some medication to see if it would stimulate the patient's menstrual cycle.

20. On or about September 8, 2003, Respondent saw Susan O. for a follow-up office visit. The patient still had not resumed her menses, despite the medications prescribed.

21. During October 2003, Respondent saw Susan O. several times to measure the patient's endometrial lining and ovarian follicles, among other things. At that time, Susan O.'s uterine fundus[6] measured .44 centimeters, which was much thinner than it should have been for Susan O. to sustain a viable pregnancy.[7] Respondent informed the patient that her endometrium was very thin and that the chances of being able to support a pregnancy were very slim. Respondent said the ablation she had performed probably caused the endometrium to get thinner.

22. During November 2003, Susan O. saw Respondent several times. At that time, the patient still had not resumed her monthly menses. Respondent told the patient that the

---

6. Fundus, in medicine, refers to the bottom or base of an organ.

7. In order for a fertilized egg to implant in the endometrium and the ability to carry a pregnancy the endometrium would have to return to a thickness of at least 8 to 10 millimeters.

likelihood of responding to any more estrogen was very slim, as they had tried for almost three months with no success. Thereafter, the patient stopped treating with Respondent.

23. In a sworn deposition, taken on January 13, 2005 in a civil action brought by Susan O. against Respondent, among others, Respondent admitted that: she knew Susan O. had been trying to get pregnant and was going to try to become pregnant after the surgery; she did not explain any other treatment option with the patient at the May 8, 2003 office visit, other than the hysteroscopy and D&C with possible polypectomy (polyp removal); she did not discuss or explain, at any time before the surgery, the endometrial ablation procedure, nor did Susan O. agree to undergo such a procedure; and Susan O. did not have a condition that would warrant undergoing an endometrial ablation.

24. In Respondent's care and treatment of Susan O. the following acts and omissions constitute repeated negligent acts:

A. Failing to obtain informed consent prior to performing an endometrial ablation;

B. Performing an endometrial ablation on a patient who desired to become pregnant;[8]

C. Failing to notify the patient, in a timely manner, of the endometrial ablation, an unplanned surgical procedure, and its ramifications;

D. Failing to inform Susan O that endometrial ablations are contraindicated in women wanting to become pregnant;

E. Failing to adequately ascertain and evaluate the history and nature of Susan O.'s mid-cycle bleeding, and any associated mid-cycle or ovulatory pain;

F. Failing to order hormonal levels (e.g., FSH, estradiol or progesterone) and thyroid studies[9] during the May 8, 2003 office visit; and

---

8. Gynecare's "ThermaChoice III" literature states that the device is contraindicated for use in a patient who wants to become pregnant in the future.

9. Thyroid dysfunction can lead to symptoms of menstrual irregularities.

G. Failing to offer alternative options to the hysteroscopy and D&C.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

25. Respondent is subject to disciplinary action under section 2234 subdivision (d) in that she exhibited incompetence in the care and treatment of patient Susan O. as follows:

26. Paragraphs 8 through 24 inclusive, above are incorporated by reference herein as if fully set forth.

27. In a sworn civil deposition, taken on January 13, 2005 as specified above, Respondent admitted that: utilizing the ThermaChoice device as a cauterizing method was improper; she did not advise Susan O. to take birth control or use some form of contraception after the endometrial ablation; and she did not discuss the risk involved in becoming pregnant after such a procedure, other than "a chemical miscarriage" due to the inability of a fertilized egg to implant in the endometrium.

28. The following acts and omissions of Respondent exhibited incompetence during her care, treatment, and management of patient Susan O., whether considered individually and/or collectively, by:

A. Performing an endometrial ablation on a patient who desired to become pregnant when it is contraindicated in such women;

B. Failing to prescribe and/or recommend post ablation contraception or birth control necessary to safeguard against potential severe life threatening complications, to the fetus and/or mother, in women who become pregnant after endometrial ablations;

C. Failing to appreciate the potential for uterine perforation when the pressure of the ThermaChoice ablation device kept dropping and could not be stabilized during the procedure; and

D. Utilizing an endometrial ablation to cauterize generalized bleeding during a hysteroscopy and D&C, when alternative methods for cauterization were available.

//

//

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

29. Respondent is subject to disciplinary action under section 2266 in that she failed to maintain adequate and accurate medical records relating to her care and treatment of patient Susan O. as follows:

30. Paragraphs 8 through 27, inclusive, above are incorporated by reference herein as if fully set forth.

31. In Respondent's initial operative report, dictated June 2, 2003 as specified above, Respondent: did not note the pressure problems of the ThermaChoice endometrial ablation device; reported a preoperative and postoperative diagnosis of menorrhagia,[10] a condition the patient did not have; reported the endometrial ablation lasted 8 minutes, and the endometrium was appropriately charred, when charring is not seen after utilization of the ThermaChoice device; and estimated the patient's blood loss at 15 to 20 cc.

32. On or about October 28, 2003, Respondent prescribed Clomid, for the patient, but failed to document the prescription in the patient's medical records.

33. On or about September 17, 2003, more than three months after the June 2, 2003 surgery, Respondent dictated an Amended Operative Report. In the amended report Respondent stated that: there was generalized bright bleeding at the site where the polyps were; [11] the ThermaChoice was used to cauterize the bleeding areas; the water through the ThermaChoice was circulated for about 3 minutes; the endometrium looked slightly pale but normal; and the patient's blood loss was between 150 to 200 cc.

34. In her sworn civil deposition, taken on January 13, 2005 as specified above, Respondent admitted that Susan O. did not have menorrhagia.

35. In a taped interview with the Board, on February 1, 2007, Respondent

---

10. Menorrhagia is excessive uterine bleeding occurring at the expected intervals of the menstrual periods, but is heavier than ususal and may last longer.

11. The pathology report from the specimens sent to pathology following the surgery noted that no definite features of endometrial polyp were identified.

admitted that she failed to document, in the patient's chart, the June 23, 2003 conversation in which, she claims, she advised the patient that an endometrial ablation had been performed.

36. In her care and treatment of Susan O., Respondent failed to maintain adequate and accurate medical records in her care and treatment of Susan O. by:

A. Failing to note the pressure problems of the ThermaChoice device during the surgery;

B. Reporting the patient's preoperative and postoperative diagnosis as menorrhea, a condition the patient did not have;

C. Reporting the patient's estimated blood loss as 15 to 20 cc, when the blood loss was in fact 150 to 200 cc;

D. Failing to document that she fully explained the inappropriate use of the endometrial ablation to the patient;

E. Failing to document the Clomid prescription during the October 28, 2003 office visit;

F. Dictating an Amended Operative Report more than three months after the surgery, which contained significant differences from the initial operative report, with no documentation to explain those differences.

//

//

//

//

//

//

//

//

//

//

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number A38363, issued to Mona P. Tahilramaney, M.D.; a.k.a. Mona P. Ramaney or Dr. Ramaney.

2. Revoking, suspending or denying approval of her authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Mona P. Tahilramaney, M.D., if placed on probation, the costs of probation monitoring to the Division of Medical Quality; and

4. Taking such other and further action as deemed necessary and proper.

DATED: October 10, 2007

BARBARA JOHNSTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2007502299

50187638.wpd